

to degenerative changes; and the reason of its being most marked in the lumbo-sacro-gluteal region may be due (1) to the comparatively small number of vessels in that region; (2) to pressure from decubitus. Further investigation of the subject is at any rate desirable; for the study of any phenomenon, however apparently insignificant, may in time lead to important discoveries.

### MALTHUS'S LAW AND TUMOUR-GROWTH.

By RUSHTON PARKER, B.S., F.R.C.S.,  
Professor of Surgery in Liverpool University College.

MR. JONATHAN HUTCHINSON has asserted several propositions, under this head, in a short pathological memorandum, on March 20th last, beginning "Malthus's law of population-increase, by geometrical progression, applies to the growth of tumours. The larger they have become, the more rapid is their rate of progress." If this law be ever really applicable, it can only hold in the case of tumours that are solid from the commencement and throughout. Whether, even in these cases, it exist or not, I cannot say; but that it cannot in a great many cystic tumours, and in numerous solid tumours that have become cystic in part, is evident. For Mr. Hutchinson says of their progress: "It is a process of cell-multiplication; and the more numerous the cells, the greater the result of their doubling." To be of any service in clinical practice, such law should, at least, be generally applicable. That, however, it can never be; because of a feature in the life of tumours, an apparent rate of growth, that entirely transcends the real rate. I allude to the adventitious effusion into solid tumours of serous or colloid fluids, or liquid or solidified blood. These effusions are quite common in malignant tumours of all kinds, especially the sarcomata, as well as in solid benign tumours composed of, or containing, cystic structures capable of serous and sanious distension; and are also met with in the simplest solid benign tumours. It is quite a common history, of this or that tumour, that it has steadily grown in size during so many weeks, months, or years after first notice; but has increased with rapidity during the few days, weeks, or months preceding a certain inspection. Even apart from cases in which cystic or hæmorrhagic effusion is discoverable to the touch or trocar, there is always a proportion of cases in which this effusion, previously unsuspected, is first made apparent when the tumour is laid open. Many a benign tumour, that has remained stationary for a period, by sudden increase becomes inconvenient, and may be thought to simulate malignancy. After removal, or otherwise, or laying it open, the cause is perceived in effusion, that may or may not have been previously suspected. Such rapid increase may overdistant the coverings of the tumour; and so, by ulceration and bursting of the skin, lead to protrusion and a kind of fungation of the growth, another feature that may be thought to simulate malignancy. Even a malignant tumour, on rapidly becoming enlarged, is easily supposed to have assumed a character of unwonted or hopeless inveteracy; such increase being found, on dissection, to be merely due to adventitious effusion; whereas the tumour, in its solid portion, is sometimes seen to have been little more than stationary. These adventitious effusions are no part of the increase proper to the tumour-tissue; but they are a clinical reality that should always be taken into account under circumstances of rapid enlargement.

I, therefore, cannot see that "it is important to remember this law," or that "it may help us, in prognosis, in emphasising the importance of early treatment," or, for the matter of that, in any way at all; since the rate of a tumour's apparent growth is no sure guide to the rapidity of its real increase.

### CLINICAL MEMORANDA.

#### SHOULDER-JOINT FRICTION AND INCIPIENT PHTHISIS.

My object in this brief communication is to draw attention to a certain physical sign that not unfrequently leads to error. As the first physical sign of incipient phthisis is frequently a mere adventitious sound heard over some part of the apex of the lung, and as the friction produced in the shoulder-joint, by breathing, often imitates very closely these pulmonary adventitious sounds, it is not difficult to understand how mistakes in diagnosis should occur.

I think that there are good grounds for believing that lives are sometimes rejected at insurance-offices, from a want of knowledge on this point.

The sound produced at the shoulder-joint is almost always of a dry quality, rather creaking than crepitation; but its character varies considerably. It is difficult to prevent its occurrence in those subjects

in whom it is heard; so that fixing the joint hardly aids one much in the diagnosis. But the sound is always loudest over the joint itself, and is better conducted along the bones than along the muscles, over which it is usually faintly heard; but in some instances it may even be audible over the pectoralis major below the clavicle. An important point in the diagnosis is the character of the breath-sound at the apex of the lung; when mere joint-friction is heard, there is of course no prolongation or increased loudness of the expiration. This friction-sound, simulating pulmonary adventitious sounds, was first pointed out to me, and, so far as is known, was first drawn attention to, by Dr. Gowers, in his class of clinical medicine at University College. It is of frequent occurrence, and especially, I think, in patients who have suffered from "rheumatism." I have not heard it often in children, and less often in women than men. There can be no doubt that the practical physician must have become acquainted with the sound, even though he may not have formulated his opinion thereon. If this note should lead to its wider recognition, my end will have been answered.

ANGEL MONEY, M.D., M.R.C.P.,  
Assistant-Physician to Victoria Park Chest Hospital, and to  
the Hospital for Sick Children, Great Ormond Street.

#### A FOREIGN BODY IN THE VERMIFORM APPENDIX.

IN the report of a meeting of the Clinical Society of London, held on December 11th, 1885, I find a statement, made by Mr. Bryant, to the effect that he had heard Sir William Jenner express his disbelief in the vermiform appendix ever becoming the seat of a foreign body. Mr. Symonds also stated that, of twenty-four recorded cases, twenty-three were due to concretions, and only one to a foreign body. I am thus induced to place on record a case which came under my observation recently.

The patient was a young man, aged 23, and had, for several weeks, been complaining of abdominal pains, referred chiefly to the umbilicus. Besides this, there had been a general failure of health. He had not taken to his bed till the day before I saw him, and on which he died, and had been going to his office to the last. His condition had become suddenly worse on the day before he died. Dr. Mackellar and myself were asked to see him by Dr. Kingdon, and he died in our presence. His later symptoms were vomiting of bilious matter and those of general peritonitis. His bowels were freely opened the night before he died. There was nothing to point to any particular portion of the intestinal tract, and the general agreement of opinion was in favour of perforation from an unknown cause. On *post mortem* examination, I found general peritonitis, with numerous adhesions, some of which were partially organised. In the vermiform appendix, there was a perforation, but no collection of pus in its neighbourhood. In the pelvic cavity, I found a cherry-stone, which had evidently set up all the trouble.

The case is of considerable interest, partly as showing that there is some foundation for the name of cherry-stone catcher, as applied to the appendix in the dissecting-room, and also in showing how long peritonitis may exist without causing very serious inconvenience. The probability is, that an abscess had formed at the seat of irritation; and from it the peritonitis had extended, and become general. The climax was brought about by the bursting of the abscess, and the accession of the acute attack. No doubt, the presence of the general chronic peritonitis diverted the attention from the real seat of trouble.

R. HAYNES LOVELL, L.R.C.P. Lond., M.R.C.S. Eng.,  
Sydney, New South Wales.

### SURGICAL MEMORANDA.

#### REMOVAL OF FOREIGN BODIES FROM THE EAR.

I WISH to suggest another mode of extraction of foreign bodies from the ear, which has never yet failed me, and seems simpler and better than the "best," as recommended by Mr. Hutchinson. I do not offer it as new, and certainly not as my own; but I have used it for years, and with constant success, even after the failure of others. Yet the article in the JOURNAL of April 10th would lead to the inference that it is not generally practised.

A large syringe holding four or six ounces, a basin of rain-water soap-suds as hot as can be borne, and a steady hand, are all that is required. With this simple apparatus, I have, over and over again, removed cherry-stones, beads, buttons, slate-pencils, etc., from the ears of children, and always without pain; nor has it ever failed me. The injection of a few syringefuls will generally suffice.

I can imagine a substance so forcibly driven into the ear that this method would not dislodge it; but then neither would the loop.

J. H. GRAMSHAW, M.D., F.R.C.S.